



**Risk Management Division**  
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**Wayne Franklin, Risk Manager**

Date: November 30, 2004

To: Elected and Appointed Officials  
Board of Education  
Department Heads

From: Wayne Franklin, Risk Manager

Subject: Workers Compensation Guidelines and Employee Acceptance

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FOR DISTRIBUTION TO AND RESPONSE FROM ALL COUNTY EMPLOYEES

This notification is to inform all Williamson County employees of their responsibility for reading and understanding the 2004-05 Workers Compensation Guidelines and Williamson County Workers Compensation Anti-Fraud Plan in the event they are injured on the job.

Risk Management has linked to its web page the instructions and forms necessary for all employees to familiarize themselves with procedures regarding Workers' Compensation claims. Documents included are:

- 2004-05 Workers Compensation Guidelines
- Williamson County Workers Compensation Anti-Fraud Plan
- C-20 First Report of Injury for Board of Education
- C-20 First Report of Injury for County General
- C-42 (Substitute) Employee's Selection of Physician

Employees that need to have copies provided to them, or have any questions regarding Workers Compensation should contact Risk Management at (615) 790-5466.

Please sign the attached acknowledgement of receipt and understanding of the above instructions. Give your signed form to your supervisor to be returned to Williamson County's Risk Management Department. **It is each supervisor's responsibility to ensure that all acknowledgements are signed and returned to Risk Management.**

[www.williamsoncounty-tn.gov](http://www.williamsoncounty-tn.gov)

or

[http://www.williamsoncounty-tn.gov/williamson/live/info.asp?page\\_s=2826](http://www.williamsoncounty-tn.gov/williamson/live/info.asp?page_s=2826)

Workers' Compensation Guidelines  
And  
Workers' Compensation Anti-Fraud Plan

Employee Acceptance Form

It is mandatory that this form be signed, dated and returned to the employee's  
immediate supervisor to be forwarded to Risk Management.  
A copy of this signed form is to be kept at the location of employment.

I have read or had read to me the Workers' Compensation Guidelines for Williamson County Government, Williamson County School System and Williamson County Volunteer Firefighters.

I have read or had read to me the Williamson County, Tennessee Workers' Compensation Anti-Fraud Plan.

I understand that it is a crime to provide false, incomplete or misleading information to any party to a workers compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

I understand that if possible I should notify my supervisor immediately in the event of a job related injury or illness. Work related injuries or illness must be reported within 30 days. I understand that I must sign all appropriate forms.

I understand that I must choose one of the authorized physicians or seek medical treatment at the named medical facility in the event I am injured or contract an illness due to a work related incident.

I further understand the importance of an injury or illness as a result of a job related incident and understand that if I seek medical treatment or attention from any physician or facility other than those authorized, and/or do not follow the treatment prescribed by said physician and/or physical therapist I will become responsible for the payment of my own medical bills.

\_\_\_\_\_  
Employee Name Printed

\_\_\_\_\_  
Employee Name Signed

\_\_\_\_\_  
Location / Department

\_\_\_\_\_  
Date